Truth lies in the eye of the beholder

The article "The repressed memory controversy: Is there middle ground?" (*Can Med Assoc J* 1996;155: 647-53), by Dr. P. Susan Penfold, was a thoughtful consideration of the subject. I was disturbed, though, by the tone of the letters by Dr. Paula Tyroler and Adriaan J. Mak (*Can Med Assoc J* 1997;156:344-5). Their positions are clear — they do not believe that memories can be forgotten (repressed) and then remembered. How can we *not* repress memories? We cannot possibly remember everything that happened to us, although all the events are likely stored somewhere in our brains. What we choose, unconsciously, to forget and to remember is largely out of our control.

As a practising general-practice psychotherapist with several years' experience with abuse survivors, I am only too aware of how fickle memory is. Even people who have experienced the same event in childhood remember it differently, simply because they are 2 individuals with different views and models of the world. The "truth" lies in the eye of the beholder and often changes with time.

I have certainly had patients whose fantasy-prone personalities have enabled them to embellish memories, not out of malice, but to provide understanding of their anxiety-ridden lives. It is this group that is especially prone to the plethora of lay therapists who use guided imagery and hypnosis to ferret out "repressed" memories. I agree with Tyroler that there is probably no way to distinguish between true memories and pseudomemories. However, to the patient the memory is true; it is a part of his or her experience. As therapists we need to help the patient heal that memory and thus himself or herself. A serious problem arises when we take the memories that are told to us by patients in a therapeutic setting and bring them into the external world as "truth." I do not believe it is necessary, or indeed advisable, to encourage patients to "confront the perpetrator" as a method of healing.

Mak is concerned about the people over 60 years of age who "tell the world these accusations are false," and so am I. It is equally painful to be wrongfully accused as is to be wrongfully treated by an abuser. However, it is surely equally possible that these accused have "repressed" their memories, or that they remember events differently, or that they simply deny them. Who would not deny such a heinous act?

There is much to be learned, and it does not serve us well to take the polarized views of Tyroler and Mak any more seriously than the views of those who believe that every memory really happened.

Edward Leyton, MD
Kingston, Ont.

Lies students tell

I am responding to the article "Teaching medical students to lie" (*Can Med Assoc J* 1997;156:219-22), by Dr. Tara A. Young, which focused on the use of "deception, dishonesty and outright lies" in the resident-application process. I was intimately involved in the organization of the PGY-1 surgical match, a forerunner of the current Canadian Resident Matching Service (CaRMS) match, and I must take issue with the negative and despairing tag she has placed on the current process. I believe we were faced with a difficult situation and have responded with an imperfect but fair process.

With the current emphasis on fiscal restraint, the reality of applying for a job — and that is exactly what the prospective resident is doing — can seem rather bleak. When the number of graduating students is high and the number of jobs, especially with health care restructuring, is decreasing, the competition becomes intense. In many other professions, such as law, a large proportion of graduates simply do not find jobs. As in law, the problems facing medicine do not lie in the application process but in the numbers game.

At the root of our collective conundrum is our inability to use an application or even an extended interview to determine who will ultimately be a successful practitioner in a particular specialty. We employ many criteria every year, but proven criteria are scarce. Regardless, candidates still attempt to judge which are the "best programs," just as program directors strive to find the "best applicants."

Young implies that the application process means that future residents can appear absolutely committed to a variety of subspecialties. I disagree with that in part, for the CaRMS application process has a place for 3 specific referees; although some applicants do provide literally dozens of reference letters that become part of their file, the 3 primary letters often indicate what the *real* career choice is. Every applicant must also detail the number of electives taken, and this helps define the commitment of a student to a particular specialty. Young should know that, although the interview process is important and we value the personal contact (however brief) with individual applicants, we generally pay more attention to what people have done than to what they say they will do.

Just as a marriage proposal is not prudent on the first date, so the com-

mitment to a resident by the program and to a program by the resident is more comfortably made after daily exposure during an elective. That kind of contact is far more valuable than any number of interviews or letters of reference from people the program director does not know.

Young entered a much-sought-after program and was obviously very well qualified. The number of programs she applied to does not reflect the dishonesty of the system as much as her insecurity about being accepted. That is a trait possessed by almost every applicant to every job in the 1990s, and it will not soon change.

Meanwhile, we will continue with a flawed but fair system in which, human nature being what it is, candidates will self-aggrandize and flatter programs and programs will self-aggrandize and flatter candidates. In the end, however, the vast majority of students will be placed in programs high on their lists.

Bryce R. Taylor, MD
Chair
Division of General Surgery
Associate Chair
Department of Surgery
University of Toronto
Toronto, Ont.

I found this article quite amusing. Young describes a moral dilemma faced by many students during interviews for residency positions: be honest, or lie to get ahead. I can assure her that this will not be the last nor even close to the greatest strain on moral integrity that these young physicians will encounter. Yet many do indeed fail this minor test of integrity by choosing to lie. They then justify their lack of integrity by saying that everybody is doing it and that the end justifies the means, since being truthful may be very costly.

In keeping with current trends in ethics, rather than laying the blame with those who tell the lies, Young accepts their justification and then provides an even better excuse. She asserts that the process has taught these students to lie. This presupposes that these talented students arrived at medical school unable to lie and with their integrity intact. Then, without a lecture, seminar or lab on the subject, these clever men and women were finally taught to lie. If only we could teach physiology or pharmacology as efficiently!

I suspect that medical students actually learn mendacity during their childhood like everyone else. Later, like everyone else, some will learn to stop lying and acquire integrity. Many do not. It should be apparent to Young and her mentors that the residency match does not teach students to lie. It simply identifies those who do.

Mark A. Healey, MD
Department of Surgery
Royal University Hospital
University of Saskatchewan
Saskatoon, Sask.

I read Young's excellent paper, for which she won a deserved prize. I fear, however, that she has missed the point in her criticism of honesty. The ability to deceive and lie is really part of the assessment process for young residents so that the assessors may determine who will be capable of facing the real world when they enter independent practice.

Physicians must now be able to deal with bureaucrats, the media, provincial health authorities and, of course, politicians, all of whom are skilled in being economical with the truth. She will find in the world that our own colleagues are not immune to this practice, nor are some of our patients.

In medicine the whole process begins when the aspiring medical student is asked that famous question — "Why do you want to be a doctor?" — and obviously it continues once this hurdle has been successfully managed.

Young's comments are admirable and altruistic, but out in the real world there is a jungle.

Martin Austin, MD
Calgary, Alta.

Young correctly points out the lying and deception that goes on in the CaRMS match. The applicant's fear of not being matched is reinforced by school administrators who ultimately are more concerned about matching all of their candidates and making their program look successful than about students' integrity, aspirations and happiness in their matches.

Institutionalized deception is rampant and contrary to professional honesty, and it requires intervention. However, honesty begins within the candidates, and it is their choice whether they will give in to this competitive deceitfulness. Once individuals say No, the lying will stop. I think it is better to be unmatched and maintain your integrity than to be matched to an undesirable program and regret the lies on your application.

I also was involved in the CaRMS match of 1996. I made the decision to go into family medicine in my fourth year despite my previous attraction to obstetrics and gynecology. I believe I got into my program of first choice because I was honest about my change of heart and my references supported my decision. I do not think I am unique in being successful and honest in the CaRMS match. I can only encourage those preparing to enter it to yield to the threat of being unmatched and present themselves as they are. I think they will find that honesty goes farther than lies.

I also believe in the confidentiality of the CaRMS match, which means that programs are not permitted to ask questions about candidates' rank-order list. This information should be irrelevant to the programs, since they

should instead focus on ranking the top candidates.

Sandy Tigchelaar, MD
Family Medicine Resident
Queen's University
Kingston, Ont.
Received via e-mail

[The author responds:]

The writers raise some interesting issues. I would like to emphasize Dr. Taylor's important point that, despite the flaws and imperfections in our existing CaRMS program, it is still a very good system. I chose to focus particularly on one issue: how the system may reward dishonesty. My intent was to stimulate discussion of an issue that has not been addressed in the literature.

Taylor draws our attention to a very precise example of how the system allows, if not encourages, applicants to behave dishonestly. Currently, candidates have the option of either sending their reference letters to programs via CaRMS or directly. Specific letters can be directed to specific programs, thereby masking the applicant's true intentions. Although Taylor may be correct in contending that an applicant's true intentions may be revealed in the list of electives required on the CaRMS general application, a candidate may have done electives in 2 closely linked specialties such as obstetrics/gynecology and family medicine, which complement each other. This would still allow the candidate to appear interested in either option. Perhaps we should consider returning to the previous and perhaps more honest system in which an applicant used the same 3 reference letters for each program.

Dr. Healey addresses important points about the source of lying behaviours. I feel these issues merit further discussion separate from the issues that I have raised. I do not seek to analyse, understand or justify the behaviour of students who lie: I am only observing a behaviour that the system unwittingly endorses by reward. Dr. Austin argues that deception is justifiable in the CaRMS process because it is a necessary skill for the "real world," which is a "jungle." I do not believe that any benefit of lying can justify its action. Dishonesty should not be accepted in medical practice simply because it is found in other professions. Our profession, which professes truthfulness as a value, must not institutionalize incentives for lying.

I appreciate Dr. Tigchelaar's support for my view of the inherent dishonesty in the resident-selection process. In her case, truthfulness brought her deserved success. Despite the weighty factors that regrettably take priority over integrity, her reminder that honesty begins within each candidate should be heeded by all. However, what about those who were honest and did not get their first choice as she did? If only Tigchelaar's anecdotal case could be generalized and could make every applicant feel confident that choosing honesty will bring the highest chance of success. This is a goal worth striving for.

Tara A. Young, MD
Resident
Department of Ophthalmology
University of Toronto
Toronto, Ont.

Needle-stick concerns

Thank you for the article "HIV postexposure prophylaxis: new recommendations" (*Can Med Assoc J* 1997;156:233), by Dr. David M. Patrick.

I work in a small community hospital where needle-stick injuries are not uncommon. In most cases the HIV status of the patient involved is unknown, but the prevalence of HIV infection in our community appears to be quite low. Unfortunately, patients are not always willing to undergo HIV testing after a health care worker has received a needle-stick injury. What is the appropriate course of action when the HIV status of the patient involved is unknown?

Jeffrey R. Sloan, MD
Richmond Medical Centre
Napanee, Ont.

[The author responds:]

Dr. Sloan raises a practical issue. Most guidelines call for initiation of antiretroviral therapy following percutaneous or mucous-membrane exposure to potentially infectious body fluids from persons known to be HIV-positive or who are at high risk for HIV infection. Potentially infectious fluids include blood and semen, and vaginal, cerebrospinal, synovial, pleural, peritoneal, pericardial or amniotic fluids. People at high risk for HIV infection include men who have sex with men, injection-drug users, people who received multiple blood transfusions between 1978 and November 1995 and sexual partners of the people in these risk groups.

When less is known about the patient, every effort should be made to counsel him or her about HIV and to obtain consent for HIV testing. When patients fully understand what is at stake for the health care worker, most will proceed with the test. A few days of antiretroviral therapy may then be prescribed for the injured worker, with a decision on further treatment made on receipt of the result.

Even if testing is not done, details about possible high-risk behaviour may be pursued during counselling. If such a history is unambiguously absent, postexposure prophylaxis may be legitimately deferred in most cases. Sloan correctly implies that when HIV status or risk status cannot be determined, judgement is more